South Carolina Department of Health and Human Services

DISABILITY REPORT – Adult

☐ **Initial** ☐ **Retro Only**

Instructions: This form is used to request a disability determination as an eligibility requirement for Medicaid. ***It is the responsibility of the Medicaid Eligibility Worker to ensure that each blank is completed.*** A copy of the completed form must be maintained in the case record.

Applicant: _____ Social Security No.: _____
(Please Print)

Date of Birth: _____ Sex: ☐Male ☐Female If Deceased, Date of Death: _____

Applicant's Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Telephone: (_____)_____

Contact Person: _____ Telephone: (_____)_____

Relationship to Applicant: _____

Contact Person's Address: _____
City State Zip Code

I. DISABILITY

a) What is your disability?_____

_____

_____

b) Are you working now? ☐ Yes ☐ No *(If yes, DHHS Form 3218E is required.)*

If no, when did your disability stop you from working? _____Month_____Day_____Year

[If date is within Retro period (3 months prior to application date), DHHS Form 3218E is required.]

Explain why you stopped working:_____

_____

_____

c) Have you applied for SSI Disability benefits? ☐ Yes ☐ No

If yes, date of application:_____

Was application made in SC? ☐ Yes ☐ No If no, what state?_____

d) Have you applied for Social Security disability benefits? ☐ Yes ☐ No

If yes, date of application:_____

If denied by SSA, have you asked them to reconsider your claim? ☐ Yes ☐ No

Did SSA refuse to reconsider your claim? ☐ Yes ☐ No

Did you request an appeal or hearing? ☐ Yes ☐ No

II. MEDICAL INFORMATION

NOTE: If you need additional space for medical sources, list their names, addresses and reasons for visits in the "remarks" section on page six or attach a separate piece of paper.

a) List name, address and telephone number of the doctor who has your most recent medical records. *(We need a complete address to request medical records.)*

Name_____ Telephone ( ) _____

Street Address_____

City_____ State_____ Zip Code_____

Date first seen:_____ Date last seen:_____ Next appointment:_____

Reason for visits _____

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b) Have you seen any other doctors since your disability or injury began? ☐ Yes ☐ No
If yes, complete the following. *(We need a complete address to request medical records.)*

Name_____ Telephone ( ) _____

Street Address_____

City_____ State_____ Zip Code_____

Date first seen:_____ Date last seen:_____ Next appointment:_____

Reason for visits _____

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c) Have you been hospitalized or received emergency treatment for your illness or injury?
☐ Yes ☐ No If yes, complete the following. *(We need a complete address.)*

Name of Hospital_____ Patient Number_____

Street Address_____

City_____ State_____ Zip Code_____

Were you an in-patient (stayed at least overnight)? ☐ Yes ☐ No

Admission Dates:_____

Reason for Hospitalization or Emergency Room Treatment_____

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d) Have you received treatment from a hospital outpatient clinic or other type of clinic?
☐ Yes ☐ No If yes, complete the following. *(We need a complete address.)*

Name of Clinic_____ Patient Number_____

Street Address_____

City_____ State_____ Zip Code_____

Date(s) of Treatment:_____

Reason for Treatment_____

_____

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e) Have you had any special diagnostic outpatient studies (x-rays, blood tests, EKG's, etc.) performed at a hospital or private laboratory/clinic? ☐ Yes ☐ No
If yes, complete the following. *(We need a complete address.)*

Type of Study/Test_____

Name of Hospital, Clinic or Laboratory_____

Street Address_____

City_____ State_____ Zip Code_____

When were these studies done?_____

_____

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f) Have you been evaluated (examination or testing), or treated by any of the following agencies?

1.	S.C. Department of Mental Health Clinic	☐ Yes	☐ No
2.	Alcohol and Drug Facility	☐ Yes	☐ No
3.	South Carolina Health Department Clinic	☐ Yes	☐ No
4.	S.C. Department of Disabilities & Special Needs OR Mental Retardation Facility	☐ Yes	☐ No
5.	Veterans Administration	☐ Yes	☐ No
6.	Vocational Rehabilitation	☐ Yes	☐ No
7.	Other ☐ Yes ☐ No If yes, identify: _____		

For each of the agencies listed above for which you have been seen, complete the following:

Name of Facility: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Date first seen:_____ Date last seen: _____ Next appointment: _____

Type of Treatment or Evaluation Received: _____

Case Manager: _____ Telephone: (_____) _____

Name of Facility: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Date first seen: _____ Date last seen: _____ Next appointment: _____

Type of Treatment or Evaluation Received: _____

Case Manager: _____ Telephone: (_____) _____

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g) Has your doctor told you to restrict your activities in any way? ☐ Yes ☐ No
If yes, give the name of the doctor and state what he told you.

_____

_____

III. EDUCATION/TRAINING INFORMATION

a) What is the highest grade of school you completed and when? _____ Grade _____ Year

b) Did you attend college, trade/technical school, or special training? ☐ Yes ☐ No
If yes, complete the following:
Type of college, trade/technical school, or special training _____
Indicate the years attended: _____ to _____ Did you graduate? ☐ Yes ☐ No

c) Did you attend special education classes? ☐ Yes ☐ No If yes, complete the following:
Name of School _____
Street or Post Office Address _____
City _____ State: _____ Zip Code: _____ County: _____
Dates Attended: _____ to _____ Type of Program _____

IV. INFORMATION ABOUT YOUR WORK HISTORY

a) Have you worked in the past 15 years? ☐ Yes ☐ No

b) If yes, give the title of the job you held the longest: _____

Give dates you held **this job**. From: _____ To: _____

What did you do all day in **this job**? _____

_____

_____

In **this job,** how many total hours each day did you:

Hrs/Day		*Hrs/Day*	
_____	Walk	_____	Kneel (*bend legs to rest on knees)*
_____	Stand	_____	Crouch *(bend legs and back down and forward)*
_____	Sit	_____	Crawl (*move on hands and knees)*
_____	Climb	_____	Handle, grab or grasp big objects
_____	Stoop (*bend down and forward at waist)*	_____	Write, type or handle small objects

_____ Lift and Carry *(Explain what you lifted, how far you carried it, and how often you did this.)*

_____

Check **heaviest** weight lifted:

☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 50 lbs. ☐ 100 lbs. or more ☐ Other: _____

Check weight **frequently** lifted: (*By frequently, we mean from 1/3 to 2/3 of the workday.)*

☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 50 lbs. ☐ 100 lbs. or more ☐ Other: _____

c) Did you perform any other jobs in the past 15 years? ☐ Yes ☐ No
If yes, please describe: _____

_____

V. REMARKS

Use this section to answer any previous questions and to add additional information that you think will be helpful in making a decision in your disability claim.

_____

_____

_____

_____

_____

_____

_____

_____

I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE.

Print Name of Applicant/Representative: _____

Applicant/Representative Signature: _____ **Date:** _____

Relationship of Representative to Applicant: _____

FOR DHHS USE ONLY

Application Date: _____ Date Mailed to Dept of Disability Determinations: _____

Category of Application: _____ Retro Month(s) Requested: _____

County: _____ Address: _____

_____

_____

Medicaid Eligibility Worker: _____ Telephone: (_____) _____

Worker's Supervisor: _____ Telephone: (_____) _____